Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
COMPPAC TRUST OF TEXAS

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-7325-01

MFDR Date Received
July 9, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "understanding TWCC wants to move to a hospital reimbursement based on Medicare, we are asking for %-over-Medicare. We have found 140% of the Medicare allowable is fair and reasonable and has been accepted by most carriers. . . . The diagnosis code on this claim . . . falls into the category of trauma admits. Because it is a trauma diagnosis, the claim can be exempt from perdiem rates. Medicare would have allowed this facility $9,693.01 FOR DRG 211. Allowing this amount at 140% would yield a fair and reasonable allowance of $13,570.21."

Amount in Dispute: $9,882.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While Carrier acknowledges that this is a trauma admission, it has determined the per diem method of reimbursement under the ACIHFG constitutes a fair and reasonable reimbursement method under the circumstances. The services provided by the hospital were not materially different from a surgical admission for the same conditions and services rendered."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2006 to August 13, 2006	Inpatient Services	$9,882.91	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – Payment is included in the allowance for another service/procedure.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 45 – Charges exceed your contracted/legislated fee arrangement BASED ON THE PROVIDER'S CONTRACT WITH ROCKPORT 800.734.4660.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The insurance carrier reduced payment for disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement BASED ON THE PROVIDER'S CONTRACT WITH ROCKPORT 800.734.4660." Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute.

   Nevertheless, on November 16, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the alleged network and the requestor, as well as a copy of the contract between the alleged network and the insurance carrier, CompPac Trust of Texas, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31Texas Register 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available."

   While the respondent did submit a copy of the contract between the requestor and the alleged network, the respondent did not provide a copy of the contract between the alleged network and the insurance carrier, CompPac Trust of Texas, as requested by the Division. Accordingly, this decision is based on the information available at the time of this review.

   No documentation was found to support that the insurance carrier, CompPac Trust of Texas, was eligible to access the contractual fee arrangement between the health care provider and the alleged network.

   Moreover, review of the submitted information finds no documentation to support that the injured employee was a "qualified participant" under the terms of the contract. No documentation was presented to support that the injured employee was currently employed and participating in the Rockport United Network or Rockport SelectHealth Network at the time of the disputed services as required by the terms of the submitted contract. The Division therefore concludes that the disputed services are not subject to a contract between the parties to this dispute. The above payment reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services for an admission exceeding 23 hours with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that "When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9)." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 820.21. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
6. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "understanding TWCC wants to move to a hospital reimbursement based on Medicare, we are asking for %-over-Medicare. We have found 140% of the Medicare allowable is fair and reasonable and has been accepted by most carriers. . . . Medicare would have allowed this facility $9,693.01 FOR DRG 211. Allowing this amount at 140% would yield a fair and reasonable allowance of $13,570.21."
   - The requestor did not discuss or present documentation to support how reimbursement of 140% of the Medicare allowable would provide for a fair and reasonable payment for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 3, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.